Analysis of $^{11}$C-methionine Uptake in Low-Grade Gliomas and Correlation with Proliferative Activity


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**BACKGROUND AND PURPOSE:** The relationship of $^{11}$C-methionine (MET) uptake and tumor activity in low-grade gliomas (those meeting the criteria for World Health Organization [WHO] grade II gliomas) remains uncertain. The aim of this study was to compare MET uptake in low-grade gliomas and to analyze whether MET positron-emission tomography (PET) can estimate tumor viability and provide evidence of malignant transformation.

**MATERIALS AND METHODS:** We studied glioma metabolic activity in 49 consecutive patients with newly diagnosed grade II gliomas by using MET PET before surgical resection. On MET PET, we measured tumor/normal brain uptake ratio (T/N ratio) in 21 diffuse astrocytomas (DAs), 12 oligodendrogliomas (ODs), and 16 oligoastrocytomas (OAs). We compared MET T/N ratio among these 3 tumors and investigated possible correlation with proliferative activity, as measured by Mib-1 labeling index (LI).

**RESULTS:** MET T/N ratios of DA, OD, and OA were $2.11 \pm 0.87$, $3.75 \pm 1.43$, and $2.76 \pm 1.27$, respectively. The MET T/N ratio of OD was significantly higher than that of DA ($P < .005$). In comparison of MET T/N ratios with the Mib-1 LI, a significant correlation was shown in DA ($r = 0.63$; $P < .005$) but not in OD and OA.

**CONCLUSION:** MET uptake in DAs may be closely associated with tumor viability, which depends on increased amino acid transport by an activated carrier-mediated system. DAs with lower MET uptake were considered more quiescent lesions, whereas DA with higher MET uptake may act more aggressively.

**Materials and Methods**

**Patient Population**

Within the 5-year period of 2002 to 2006, we studied the metabolic activity in 49 consecutive patients with newly diagnosed WHO grade II gliomas at the Chubu Medical Center for Prolonged Traumatic Brain Dysfunction, Kizawa Memorial Hospital. All patients had space-occupying supratentorial lesions that, on CT and MR imaging, appeared highly suspicious for gliomas. We included cases of ressectable hot lesions demonstrated preoperatively on MET PET. Patients with brain stem, thalamic, and hypothalamic tumors were excluded. Presurgical radiologic evaluation was performed with MET PET and MR imaging in all patients, and all patients underwent open surgical
procedures within 4 weeks after PET scanning. Tumors were classified on histologic examination with use of the WHO classification system.20 There were 21 DAs, 12 ODs, and 16 OAs (Table). All patients gave written informed consent, and the protocol was approved by the research committee of Kizawa Memorial Hospital Foundation.

**PET Scan Procedure**

PET scan was performed as previously described.21 The PET study was carried out according to the standardized procedure used in our institution. The PET scanner was an ADVANCE NXi Imaging System (GE Yokokawa Medical System, Hino-shi, Tokyo, Japan), which provides 35 transaxial images at 4.25-mm intervals. The in-plane spatial resolution (full width at half maximum) was 4.8 mm, and the scan mode was the standard 2D mode. Before the emission scan was performed, a 3-minute transmission scan was performed to correct photon attenuation with a ring source containing 68Ge. A dose of 7.0 MBq/kg of MET was injected intravenously, depending on the examination. The emission scan was acquired for 30 minutes, beginning 5 minutes after MET injection. During PET data acquisition, head motion was continuously monitored with laser beams projected onto ink markers drawn over the forehead skin and corrected manually as necessary. The images were reconstructed with the ordered-subsets expectation maximization algorithm.

**MR Imaging Procedure**

MR imaging was performed on a 1.5T system (Signa; GE Healthcare, Milwaukee, Wis). T1-weighted images, T2-weighted images, and fluid-attenuated inversion recovery (FLAIR) images were acquired with use of our standard protocol. For co-registration of metabolic and anatomic data, we also acquired 3D spoiled gradient-echo images after administration of 0.2 mL/kg of gadopentetate dimeglumine (Magnevist; Nihon Shering, Osaka, Japan) using the following parameters: no gap; 1.0-mm thickness; TR, 20 ms; TE, 1.6 ms; flip angle, 15°; NEX, 1; and axial views.

**Data Analysis**

Tracer accumulation in the region of interest (ROI) was analyzed as the standardized uptake value (SUV), which is the activity concentration in the ROI at a fixed time point divided by the injected dose.

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**Clinical data and histopathologic results**

<table>
<thead>
<tr>
<th>Histologic Diagnosis</th>
<th>Number of Patients (M/F)</th>
<th>Age</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diffuse astrocytoma</td>
<td>21 (14/7)</td>
<td>40.9 ± 15.2</td>
<td>F</td>
</tr>
<tr>
<td>Oligodendroglioma</td>
<td>12 (8/4)</td>
<td>38.0 ± 13.5</td>
<td>F</td>
</tr>
<tr>
<td>Oligoastrocytoma</td>
<td>16 (10/6)</td>
<td>39.3 ± 13.8</td>
<td>F</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49 (32/17)</strong></td>
<td><strong>39.6 ± 14.1</strong></td>
<td>F</td>
</tr>
</tbody>
</table>

Note:—F indicates frontal; P, parietal; T, temporal; I, insular.

* Data are expressed as mean ± SD.
normalized to the patient’s measured weight. The MET SUV ratios (T/N ratios) were calculated by dividing the maximum SUV for the tumor by the mean SUV of the contralateral normal frontal cortex. The tumor maximum SUVs were selected as the highest accumulation, and the reference ROIs were drawn in 3 circular ROIs with a diameter of 10 mm on each of the 3 axial planes (Fig 1). Co-registration of PET and MR imaging was undertaken in all cases with the Dr. View, an image analysis software package (AJS, Tokyo, Japan). If increased accumulation was absent or was not clear, a ROI was selected in consultation with the fusion image. We used the T/N ratio instead of absolute SUV because of the high, unexplained intersubject variability of SUV. We used tumor maximal SUV instead of tumor mean SUV to minimize the effect of tumor heterogeneity.

**Proliferative Activity**

Tumor type and grade were determined according to the WHO classification of brain tumors from representative hematoxylin-eosin–stained slides of each tumor. An avidin-biotin immunoperoxidase or simple stain MAX-peroxidase (Nichirei, Tokyo, Japan) technique was used to perform a Mib-1 monoclonal antibody (DAKO, Denmark) assay in selected sections of each case. The Mib-1 LI was quantified visually by counting the number of mitoses in areas of the tumor showing the highest number of immunopositive nuclei. All tissue sections were examined at high-power magnification (× 400) along horizontal and vertical axes perpendicular to each other until 1000 cells were counted. Only neoplastic cells were included in the quantification of the Mib-1–positive cells. Necrotic and hemorrhagic areas and the borders of each section were also omitted from quantification. The results were expressed as the percentage of Mib-1–positive cells per 1000 tumor cells.

**Statistical Methods**

Data are presented as mean ± SD. To compare the T/N ratios among the different tumors, we performed statistical analyses with analysis of variance and a Tukey post hoc test. To determine if the MET T/N ratio was related to proliferative activity, we calculated Spearman correlation coefficients. P values less than .05 were considered statistically significant.

**Results**

**Results of MET T/N Ratio**

The mean MET SUV of the contralateral normal frontal cortex was 1.22 ± 0.37. The mean MET T/N ratio of all
Gliomas was 2.72/H110061.31. The mean MET T/N ratios of DA, OD, and OA were 2.11/H110060.87, 3.75/H110061.43, and 2.76/H110061.27, respectively, and there was a significant difference between the average MET T/N ratios of DA and OD (P < .005). One of the reasons for the higher MET T/N ratio in OD is the difference in microvessel attenuation in each glioma. As measured by immunostaining with factor VIII, OD demonstrates high microvessel counts and high MET uptake compared with malignant astrocytomas. In addition, tumor blood volume in OD was revealed to be significantly higher than that of DA on the basis of a perfusion MR imaging study. These differences of the tumor vascular bed may be one of the reasons why MET uptake of OD is higher than that of DA. The MET T/N ratio of OA fell between that of DA and OD, suggesting that OA may have mixed metabolic features of both astrocytic and oligodendroglial tumors.

One half to more than 90% of patients with WHO grade II astrocytoma experience malignant transformation. Glioblastoma multiforme (GBM) may develop from either primary or secondary pathways; thus, these subtypes of GBM may constitute distinct disease entities. The mean time to progression from anaplastic glioma to GBM was approximately 2 years, and that from low-grade glioma to GBM was approximately 5 years. Kim et al reported that Mib-1 LI correlated significantly with MET uptake in every grade of glioma. We were able to demonstrate a significant correlation in DA between MET T/N ratio and Mib-1 LI; to the best of our knowledge, this is the first clinical study to demonstrate a significant correlation between MET uptake ratio and Mib-1 LI in DAs only.

MET is a natural amino acid taken up by glioma cells, usually found at a very low concentration in normal brain tissue. The main mechanism of MET uptake is from an increase of MET transport into the tumor. In gliomas, MET uptake may be attributed to the activation of a carrier-mediated transport system at the normal blood-brain barrier (BBB). This uptake does not directly reflect protein synthesis, but it represents cell avidity for amino acids. Langen et al reported that the amino acid transport system was dependent on the proliferative activity of the human glioma cells. Increased uptake of MET is present in most low-grade gliomas despite the absence of damage to the BBB. In malignant gliomas with BBB damage, passive diffusion also contributes to total uptake of MET. We hypothesize that the MET uptake, especially in DAs without BBB disruption, may be closely associated with tumor viability, which itself is dependent on increased amino acid transport. There was no correlation between MET uptake and Mib-1 LI in ODs and OAs, which may be because of the different mechanisms of MET uptake in these tumors compared with DA. We considered that even if the MET uptake is high, ODs will not always be transformed malignantly because a tumor vascular bed often causes a high MET. The case is not the same regarding ODs with a high MET compared to DAs.

Previous reports have shown that grade III/IV gliomas demonstrate higher MET uptake than grade II gliomas. In grade II glioma (DA, 33; OD, 39; OA, 17), tumor resection had could demonstrate a significant correlation in DA (r = 0.63, P < .005; Fig 4).

**Discussion**

In this study, the MET T/N ratio of OD was the highest when compared with DA and OA, which is in agreement with previous reports. We detected a significant difference between the average MET T/N ratios of DA and OD (P < .005). One of the reasons for the higher MET T/N ratio in OD is the difference in microvessel attenuation in each glioma. As measured by immunostaining with factor VIII, OD demonstrates high microvessel counts and high MET uptake compared with malignant astrocytomas. In addition, tumor blood volume in OD was revealed to be significantly higher than that of DA on the basis of a perfusion MR imaging study. These differences of the tumor vascular bed may be one of the reasons why MET uptake of OD is higher than that of DA. The MET T/N ratio of OA fell between that of DA and OD, suggesting that OA may have mixed metabolic features of both astrocytic and oligodendroglial tumors.

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Previous reports have shown that grade III/IV gliomas demonstrate higher MET uptake than grade II gliomas. In grade II glioma (DA, 33; OD, 39; OA, 17), tumor resection had
a clear effect in patients with high MET uptake; however, no effect from surgery was found in the group of patients with low MET uptake.17 Smits et al19 analyzed DAs and oligodendrogliotic tumors (OD and OA) separately in the reevaluation of the prognostic impact of the European Organisation for Research and Treatment of Cancer (EORTC) factors after adding the MET uptake as an extra prognostic factor. The MET uptake was the most important prognostic factor in DA, and the presence of contrast enhancement on CT or MR imaging did not influence survival in both groups.19 These findings demonstrate that DA with higher MET uptake may be more likely to undergo malignant transformation. On conventional MR imaging, local enhancement or peripheral edema suggests malignant transformation; however, these changes may not always be evident in the biologic history of a grade II glioma. We considered that MET PET seems to be useful in assessing tumor histologic processes in grade II glioma and evaluating tumor viability, especially in DAs. Cases of DA with higher MET uptake will require careful therapeutic decision making because these tumors may be more prone to malignant transformation.

The limitation of this study was the lack of long-term follow-up in patients with grade II glioma. Future studies will need to examine possible correlations between MET uptake and proliferative activity in patients with both DA and secondary anaplastic astrocytoma/GBM.

Conclusions
The MET T/N ratio of OD was significantly higher than that of DA and OA. A significant correlation between MET T/N ratio and Mib-1 LI was shown in DAs. MET uptake in DAs may be closely associated with tumor viability, which depends on increased amino acid transport by an activated carrier-mediated system. DAs with higher MET uptake may be more aggressive tumors than then their counterparts with lower MET uptake.

Acknowledgments
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References